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INDEPENDENT MEDICAL REVIEW

DEPARTMENT UPDATE, NOVEMBER 30, 2000

INTRODUCTION

On January 1, 2001, the Department of Managed Health Care will begin administering a new independent medical review (IMR) program. The new system allows enrollees to request that the Department obtain an impartial review of plan decisions concerning:

- the medical necessity of a proposed treatment;
- experimental or investigational therapies for certain medical conditions; and
- denied claims for out-of-plan emergency or urgent medical services.

Under sections 1374.30 through 1374.36 of the Health and Safety Code, an enrollee may seek an IMR when dissatisfied by the plan's decision. Unlike the current Friedman-Knowles Act (Health and Safety Code Section 1370.4) and existing external reviews in plan grievance structures, requests for IMR will be received and processed by the Department. Enrollees usually will have to exhaust the plan's grievance system before applying.

This update is focused on the operational interface and communications needed among the health plans, the Department's HMO Help Center and the Department's IMR contractor when the new program begins on January 1, 2001. In addition, it will serve as a starting point for discussions at December informational meetings that are being scheduled in Los Angeles and Sacramento. These meetings, subsequent updates and the Department website all will be used to ensure that the IMR system is thoroughly understood and functions effectively for patients.

IMR PROCESS AND ORGANIZATION

HMO HELP CENTER. The IMR program will be managed within the Department's HMO Help Center in Sacramento by a team comprised of Consumer Service Representatives, a Health Analyst, Nurses, and Counsel, with oversight of clinical criteria provided by the DMHC Medical Advisor.

- Consumer Service Representatives will be responsible for receiving and processing incoming applications and ensuring that the IMR system is effective, efficient and responsive.

- The Analyst will be responsible for the oversight of the program's day-to-day operations.
- Nurses will determine whether eligible cases should be expedited, develop any case-specific questions necessary for a review and provide other analysis of the needs of a particular review, if needed.
- Counsel will be responsible for resolving whether the services in dispute pertain to a contractual or legally-required benefit. In addition, they will assess plan compliance with statutory requirements regarding grievance and IMR processes, the Department's initial review process, and the adoption of IMR determinations.

Issues relating to Department policy will be reviewed by the Department's ad hoc IMR Advisory Council, which will include representatives from various Department divisions and offices. Quality assurance and overall IMR system effectiveness will be assessed by the Director through the Medical Advisor and the Department's Clinical Advisory Panel.

INTERNAL MEDICAL REVIEW ORGANIZATION (IMRO). The Department has completed the competitive bidding process and expects to complete the contracting process by late November. The Department will likely contract with more than one IMRO to assure that the volume of anticipated requests can be accommodated. Once the contracting process is complete, the specific requirements and operational processes between the Department, the IMRO and the health plans will be provided.

STANDARD IMR APPLICATIONS AND FORMS

The Department is developing several forms for the IMR process, which will be made available on our website shortly:

- **IMR Application Form** (or other Department-approved application) must be provided to the enrollee by the plan when advising enrollees that a determination has been made that could be subject to an IMR. An application form (and an envelope addressed to the HMO Help Center) must be included when a plan issues its resolution to a grievance that finds an otherwise covered service is not medically necessary. A request to extend the eligibility period for IMR is also included.

- **Physician Certification Form** is required if the IMR application concerns services denied by the health plan as experimental or investigational. A physician certification is required to establish that the enrollee's medical condition is life-threatening or seriously debilitating and that a physician has recommended a drug, device or service as more beneficial than available standard therapies. In addition, if the enrollee's treating physician is not under contract with the plan, the request for an IMR must reference or provide two medical or scientific documents to support the benefit of the requested services.

- **Authorization for Release of Medical Records and Declaration of Relationship Form** allows a representative to act on behalf of the enrollee when an enrollee requests or requires assistance during the IMR process. The form also allows the representative to authorize release of the enrollee's medical records.

- **Health Plan Checklist** will be used by the Department's HMO Help Center to request additional information from the health plans when necessary to determine the eligibility of an IMR application. It will also provide the plan notice that the enrollee has sought an IMR following the plan's decision.

CRITICAL TIMELINES

Following is a quick-reference chart on the critical timelines for IMR processing:

CASE TYPE	EXPEDITED (MEDICAL NECESSITY)	EXPEDITED (EXPERIMENTAL)	STANDARD
Department notifies enrollee, enrollee's physician and the health plan if application is eligible	Within **48 hours** of application receipt	Within **48 hours** of application receipt	Within **7 days** of application receipt
Health Plan provides medical records/information to the Review Organization	Within **24 hours** of DMHC notification	Within **24 hours** of DMHC notification	Within **3 days** of DMHC notification
Health Plan provides new records (not available at the time of the original submission) to the Review Organization	Within **1 day** of receipt	Within **1 day** of receipt	Within **1 day** of receipt
Review Organization renders determination	Within **3 days** of receipt of records	Within **7 days** of receipt of records	Within **21 days** of receipt of records
Department adopts Review Organization determination and issues written decision	Within **1 day** of receipt of Review Organization determination	Within **1 day** of receipt of Review Organization determination	Within **3 days** of receipt of Review Organization determination

FREQUENTLY ASKED QUESTIONS

During the development of the operational processes for Independent Medical Review, the Department resolved a number of issues that may be of interest to plans as they prepare to interact with the IMR system. Additional frequently asked questions will be shared through future communications and posted on our website.

1. **Are disputes that deal with benefits or terms of coverage eligible for IMR?**
   The cases submitted for independent medical review must pertain to a disputed health care service. If the dispute involves only a question of whether a particular service is included or excluded as a covered benefit under the plan contract, the HMO Help Center will resolve the dispute without referring the case to IMR. The plan's categorization of the dispute is not determinative. Regardless of the plan's stated reason for denial, the Department may determine that the dispute inherently involved a plan finding relating to the practice of medicine and the medical necessity of a requested health care service.

   The plan, enrollee and (ultimately) the Department must be able to understand and clearly articulate both the nature of the dispute and the basis for the plan's actions. If it is unclear whether the issues involve findings relating to medical necessity or a coverage dispute, the Department will obtain information from the plan, providers or the enrollee as it deems necessary to determine whether the case should be referred to IMR.

2. **Are disputes concerning prescription benefits, such as brand versus generic medications and formulary versus non-formulary eligible for IMR?**
   Plan denials, delays or modifications to health care services based on medical necessity are eligible for IMR. Depending upon the plan structure, the plan's resolution of a drug-related grievance may be based on a finding of medical necessity and could be eligible for IMR.

3. **Before applying for an IMR due to the denial of experimental or investigational treatment, does an enrollee have to participate in and complete the health plan's grievance process?**
   The statute (Health and Safety Code Section 1370.4) allows an enrollee to apply for an IMR after the plan has denied an experimental or investigational therapy for a life-threatening or seriously debilitating disease or condition. There is no requirement that the enrollee file a grievance with the plan before contacting the Department. (Except for expedited cases, enrollees must file and participate in the plan's grievance process for at least 30 days before submitting an application for an IMR based on medical necessity).

4. **What will the independent medical reviewer determine if the case involves a dispute over the plan's refusal to reimburse the enrollee for out-of-network emergency and urgent medical services?**
   An IMR application involving a dispute over whether the plan should reimburse the enrollee for emergency or urgent services will require the Department to assess whether the dispute involves the reasonableness of the enrollee's actions to seek such care or the scope and extent of the services sought out and provided. If the former, the issue for the Department primarily depends on whether the enrollee acted as a reasonable and prudent person and can be resolved within the HMO Help Center complaint resolution process. If the Department is unable to make that determination or if the case concerns whether the services were medically necessary to provide immediate care and stabilize the patient's condition, the case will be forwarded for IMR.

5. **When does the right to IMR begin?**
   Grievances resolved or still pending at the health plan on or after January 1, 2001 will be subject to the new IMR process. The Department expects that reviews for experimental and investigation reviews under the current IMR process that have been referred to the plan's IMRO before January 1st will be completed under the terms of the current law.

6. **Will the Department accept IMR applications directly from the health plan?**
   The health plan may submit an IMR application on behalf of an enrollee, but the enrollee must consent to the IMR. (The consent can occur either prior to or after receipt of the application at the Department.)

7. **How will the Department handle after-hours requests for IMR?**
   The Department contracts with an external call center to answer calls to the HMO Help Line after hours. If a request for an IMR is received after normal working hours, the enrollee's circumstances will be assessed to determine whether it qualifies as a request for an expedited complaint or review. If so, it will be referred to a DMHC nurse who will contact the individual designated by the health plan as the "24-hour contact" – the individual who has authority to resolve urgent issues and authorize the provision of health care services.

8. **What will happen if the Department receives an incomplete IMR application?**
   The Department will attempt to contact the enrollee (or a representative) to obtain the necessary information or from the health plan through the Health Plan checklist. If the Department is unable to obtain information necessary to determine whether the case is eligible for IMR, the case will be assessed to determine whether the Department should consider the application as a complaint to the Department under Section 1368(b). The enrollee and plan will be notified of the Department's determination in writing.

9. **What happens if the application does not qualify and will not be referred to the IMRO?**
   If the IMR application does not qualify and the enrollee is not eligible to utilize the complaint process, the enrollee is notified that their application for IMR is denied. If the Department can identify an appropriate resource for the enrollee to resolve their issue, that information will be provided.

10. **How does the Department qualify an IMR case as "expedited"?**
    If the enrollee, their representative or the treating physician requests an expedited review, the case will be referred to a Department nurse consultant to determine if the enrollee's condition meets the expedited review criteria.

11. **What is the process for forwarding a case to the IMRO?**
    Immediately after an IMR application is approved, the Department will contact an IMRO for a conflict of interest screening and to initiate reviewer selection. If the IMRO is unavailable for a particular case, the Department will have at least one other IMRO under contract. When accepted for review by an IMRO, the Department will notify the health plan via facsimile and by telephone that the case has been referred for a determination. The health plan must send medical records and all

other appropriate documentation to the IMRO within the required timeframes (24 hours for expedited reviews and 3 days for standard reviews).

12. How will the enrollee be notified that their case will be reviewed by an IMRO?

The Department will also notify the enrollee, as well as any representative or physician involved in the application. In the notification letter, the Department will identify the IMRO who will be conducting the review and other information relating to the review process.

13. What happens once the IMRO sends its determination?

The IMRO determinations will be issued to the enrollee, the health plan and the Department concurrently. HMO Help counsel will receive and review the IMRO determination and will forward a formal adoption letter to the enrollee, the health plan, and the enrollee's physician. If the adoption letter requires the health plan to reverse its initial determination (the denial is overturned), the health plan must implement the binding determination and notify the Department in writing of their compliance with the determination.

WHAT CAN HEALTH PLANS DO TO MAKE THE IMR PROGRAM A SUCCESS?

- Assure that treatment authorization denials and responses to grievances clearly identify the service, procedure, treatment, therapy, medication, or device that is being denied, the number and/or type of treatments, the reason(s) for the denial, and the criteria on which the decision was based. Specific and clear language should be used to identify whether the plan's action is based upon contractual/EOC language or the result of a medical finding that the requested care was found not medically necessary. Section 1367.01 sets out specific requirements in addressing requests for medical services.

- Be sure that the Department has accurate and updated contact information for the health plan staff responsible for handling grievances and IMR requests during business and non-business hours.

- Ensure that the member handbook, plan contracts, evidence of coverage documents, grievance letters, and any other appropriate documents have information regarding the right of an enrollee to request an IMR. The IMR application and relevant information should be provided to enrollees when appropriate.

- When requested by the HMO Help Center, complete and return the Health Plan Checklist to allow for an appropriate determination of whether or not an application qualifies for IMR.

- For plans that delegate any or part of their utilization review or grievance processes, ensure that the information flow will not impede compliance to critical time frames. All requests for information will go directly to the Health Plan, not to the delegated entity. Health Plans should work to ensure that their delegated medical groups and IPAs are knowledgeable of the new IMR regulations and that points of contact are available within the groups to ensure swift response times.

- Follow the guidelines that will be provided regarding the content and organization of the IMR file submitted to the Independent Medical Review Organization.

DMHC CONTACT INFORMATION

The Department will have a team dedicated to the processing of Independent Medical Reviews. We will provide further information at the December IMR Informational meetings and on the DMHC website, including a list of DMHC staff to contact with additional questions.